GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLES

ONE-WEEK DISABILITY PARKING PERMIT APPLICATION

You may mail this form to DC DMV,Medical Review Services, PO Box 90120, Washington, DC 20090 or fax to 202-727-0463.
For additional information visit our website: www.dmv.dc.gov or call our Customer Service Call Center at 202-727-5000.

APPLICANT'S INFORMATION:

Date:_____

Name: _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE ZIP CODE

Date of Birth: ____/____/____
MM DD YYYY

Driver's License #:_____ **Exp. Date:**_____ **State Issued:**_____

Identification Card #: _____ **Identification Card Type:**_____

Exp. Date: _____ **State Issued:**_____

Telephone Number: _____ **E-mail Address:** _____

Permit Effective Date: _____ **Permit Expiration Date:** _____

I am applying for a One-Week Disability Parking Permit for one of the following reasons:

- ☐ **Vehicle with Disability Tags is Being Repaired**
- ☐ **One-Week Temporary Disability**
- ☐ **To Obtain Physician's Disability Certification**
- ☐ **Disabled Visitor**

The applicant swears or affirms the following:

I will use the Disability Parking Permit granted by the DC Department of Motor Vehicles as provided in Chapter 27 of Title 18, District of Columbia Municipal Regulations. I understand the One-Week Disability Parking Permit is not transferable to any other person and is intended for my use only. I may have a designated driver display the Disability Parking Permit only when I am a passenger in the vehicle in which the permit is displayed.

The above information is true and correct to the best of my knowledge and belief.

_____ _____
Applicant's Signature Date

The making of a false statement on this form is a violation of DC law and is subject to a fine of up to $1,000 or 180 days imprisonment or both (D.C.Official Code § 22-2405).

DMV OFFICIAL USE

Date Issued/Mailed:_____ Permit Identification Number: _____

Validation Period:

From:_____ Expiration Date: _____

DMV Examiner's Name:_____ Date: _____